

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11841

10587

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Hospital		d. STREET ADDRESS 126 Pine Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Evdana Sarrare Askins		First	Middle	Last	4. DATE OF DEATH Oct. 29 1957	Month	Day	Year
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 26, 1956	9. AGE (In years lost birthday) 1 yrs.	10. IF UNDER 1 YEAR Months 7	11. IF UNDER 24 HRS. Days 4	Hours 1	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Cambridge, Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME James Chester		14. MOTHER'S MAIDEN NAME Ruth Askins		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Ruth Askins, Cambridge, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Influenza infection 481X DUE TO						INTERVAL BETWEEN ONSET AND DEATH 1 day		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO								
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Congestive Heart Disease						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from 3/26 1957 , to 3/26 1957 , that I last saw the deceased alive on 3/26 1957 , and that death occurred at 11 P.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 104 Locust St		DATE SIGNED 10/3/57		
ACTUAL SIGNATURE W.H. Hanks M.D.								
PHYSICIAN'S NAME (Type) W. H. Hanks M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/2/1957		22c. NAME OF CEMETERY OR CREMATORIUM East New Market		22d. LOCATION (City, town, or county) East New Market, Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Robert McElroy Jr.		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR DATE 11/4/57		24b. REGISTRAR'S SIGNATURE John Mace Jr.		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF HEALTH—PHILADELPHIA
CERTIFICATE OF DEATH

BUREAU U.S.

NOV 13 1957

RECEIVED

10605

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10588

Items 11 & 12, Film G221, 10/10/57

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Dor.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge.		c. LENGTH OF STAY IN 1b. 1 yr. 4 mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge 13		d. STREET ADDRESS Edlon Park		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) BLANCHE		First	Middle	Last	4. DATE OF DEATH BRINSFIELD Oct. 3 1957	Month	Day	Year
S. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 5/13/80	9. AGE (In years lost birthday) 77 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Brookview, Dor. Co., Md. 77		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Thomas H. Brinsfield				14. MOTHER'S MAIDEN NAME Harriet McAllister				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Eastern Shore State Hospital records		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Psychosis with cerebral arteriosclerosis								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ADDRESS (Street, city or town, state)						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) E.S.S. Hospital, Cambridge, Md.	(County)	(State)
21. I certify that I attended the deceased from 5/22/56 , 19, to 10/3/57 , 19, that I last saw the deceased alive on 10/3/57 , 19, and that death occurred at 11:35 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED								
ACTUAL SIGNATURE Thomas J. Dredge M.D.								
PHYSICIAN'S NAME (Type) Thomas J. Dredge, M.D.								
22a. BURIAL-CREMATION-REMOVAL (Specify) Burial	22b. DATE THEREOF Oct 6-57	22c. NAME OF CEMETERY OR CREMATORIAL Greenlawn		22d. LOCATION (City, town, or county) Cambridge Md.		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE Benjamin L. Thomas Cambridge			ADDRESS	24a. REC'D BY REGISTRAR John Doe Jr.		24b. REGISTRAR'S SIGNATURE John Doe Jr.		
VS A15 (4) 15M 9/55			DATE 10/5/57					

DEPARTMENT OF STATE - STATEMENT OF THE POSITION OF THE UNITED STATES

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10589

10588

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Trappe		d. STREET ADDRESS R.F.D.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Benjamin		First	Middle	Last	4. DATE OF DEATH 10	Month	Day	Year	
5. SEX Male		6. COLOR OR RACE Col	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 12-28-82	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY Janitor		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Elick Brummell				14. MOTHER'S MAIDEN NAME Clara Green					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address John Copper, Trappe, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Heart Disease INTERVAL BETWEEN ONSET AND DEATH 1 yr.									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Generalized Arteriosclerosis (c) 3 yrs.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 136 Rue St		(County)	(State)
21. I certify that I attended the deceased from 9/30 , 19 57 , to 10/3 , 19 57 , that I lost sight of the deceased alive on 19/3 , 19 57 , and that death occurred at 136 Rue St , M, from the causes and on the date stated above.									
ACTUAL SIGNATURE Lawrence Marynow ADDRESS (Street, city or town, state) Lawrence Marynow DATE SIGNED 136 Rue St									
PHYSICIAN'S NAME (Type) Lawrence Marynow		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 10-7-57							
22c. NAME OF CEMETERY OR CREMATORIAL Trappe Cem.		22d. LOCATION (City, town, or county) Trappe (State) Md.							
23. FUNERAL DIRECTOR'S SIGNATURE James B. Dashiell		24a. REC'D BY REGISTRAR OCT 16 1957 24b. REGISTRAR'S SIGNATURE John Macay Jr.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10589

10590

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the remains prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Maryland b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
Cambridge		Life		Cambridge				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
34 Edgewood Ave.		34 Edgewood Ave.						
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
Lester		James	Bryan	Bryan	Oct.	9,	1957	
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (in years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Male		Negro	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	May 1, 1921	36 yrs.	Months	Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Laborer		Laborer		Dorchester Co., Md.		USA		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME						
William Bryan		Minnie Corbin						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
No		214-16-4360		Minnie Bryan, Cambridge, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hemorrhage INTERVAL BETWEEN ONSET AND DEATH 1 hr.								
783.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cause unknown								
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.								
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>John Mace Jr.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 10/9/57		
EXAMINER'S NAME (Type) John Mace Jr.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/12/1957		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Cordtown Cemetery, Cambridge, Md.		22d. LOCATION (City, town, or county) Cordtown, Dor. Co., Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Herbert McAllister Jr.</i>				24a. REC'D BY REGISTRAR DATE 10/10/57		24b. REGISTRAR'S SIGNATURE <i>J. Mace Jr.</i>		

BUREAU V

OCT 14 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please
 indicate the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be
 forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-travel permit. File Pages 1 and 2 with the remains prior to burial, cremation,
 or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10590 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10591

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Dorchester		b. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Cambridge	25 years	13 Cambridge	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21 Wells Street			
3. NAME OF DECEASED (Type or print)	First Samuel	Middle	Last Clark
4. DATE OF DEATH	Month Oct.	Day 23	Year 1957
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
Male	Negro	WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	Feb. 26, 1910
9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.
47 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Laborer		Laborer	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
North Carolina		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
John Thomas Clark		Emma Wollard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT	
No		220-10-6925 Sarah Holland, Cambridge, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>5 min.</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>John Mace Jr.</u> EXAMINER'S NAME (Type) <u>JOHN MACE JR.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Rem-Burial		22b. DATE THEREOF 10/28/1957	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Washington Ceme.		22d. LOCATION (City, town, or county) (State) Washington, North Carolina	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert McElroy Jr.</u>		24a. REC'D BY REGISTRAR ADDRESS Cambridge, Md. DATE 10/14/57	
		24b. REGISTRAR'S SIGNATURE <u>James J. ...</u>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
FEDERAL MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V.

NOV 4 1957

RECEIVED

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										10592
Item 2 FilmG221 10-22-57 et CERTIFICATE OF DEATH										Reg. Dist. No. 116
1. PLACE OF DEATH a. COUNTY		<i>Dorchester</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		<i>Cambridge</i>		c. LENGTH OF STAY IN 1b <i>5 months</i>		d. STATE		b. COUNTY		
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. COUNTY		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		<i>Eastern Shore State Hosp.</i>		d. STREET ADDRESS <i>Oxford 116 5th Street</i>		e. STREET ADDRESS		d. COUNTY		
3. NAME OF DECEASED (Type or print)		First <i>FLORENCE</i>	Middle <i>WEST</i>	Last <i>CROTHERS</i>	4. DATE OF DEATH		Month <i>October</i>	Day <i>11</i>	Year <i>1957</i>	
5. SEX		6. COLOR OR RACE <i>Female White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-19-78</i>		9. AGE (In years last birthday) <i>79 yrs.</i>		IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>				
13. FATHER'S NAME <i>James Polk West</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Unknown</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Bertha Thapsin</i>		Address <i>Oxford, Pa.</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										
<i>422.1</i>										
Cardiac Failure										
INTERVAL BETWEEN ONSET AND DEATH										
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.										
(b) Chronic Cardio-Vascular Disease										
(c) General Arteriosclerosis										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Oxford</i>	(County) <i>Chester Co</i>	(State) <i>Pa.</i>	
21. I certify that I attended the deceased from <i>Oct. 11, 1957</i> to <i>Oct. 11, 1957</i> , that I last saw the deceased alive on <i>Oct. 11, 1957</i> , and that death occurred at <i>5 P.M.</i> from the causes and on the date stated above.										
ADDRESS (Street, city or town, state)										
DATE SIGNED										
ACTUAL SIGNATURE <i>Ettore De Filippis M.D.</i>										
PHYSICIAN'S NAME (Type) <i>ETTORE DE FILIPPIS</i>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>										
22b. DATE THEREOF <i>Oct 16 1957</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Oxford Cemetery</i>		22d. LOCATION (City, town, or county) <i>Oxford Chester Co Pa</i>						
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ralph McGehee, Rising Sun, Md.</i>										
ADDRESS										
24a. REC'D BY REGISTRAR DATE <i>15 1957</i>										
24b. REGISTRAR'S SIGNATURE <i>John Macey Jr.</i>										

87. *BRONX-17 EAST 90 DEGREES TO THE SOUTH*

BUREAU V. S.

2001-100

REGELIVÉ

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10593

10591

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Dorchester</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Maryland</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cambridge</i>	c. LENGTH OF STAY IN 1b <i>1 week</i>	b. COUNTY <i>Dorchester</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Elliotts</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Cambridge Maryland</i>		d. STREET ADDRESS <i>Elliotts</i>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First <i>Lucy</i>	Middle <i>Emma</i>	Last <i>Well</i>			
4. DATE OF DEATH	Month <i>10</i>	Day <i>16</i>	Year <i>1957</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9/19/1879</i>			
9. AGE (In years from birthday) yrs. <i>78</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>			
13. FATHER'S NAME <i>William Shuster</i>	14. MOTHER'S MAIDEN NAME <i>Aquila Foster</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO.	17. INFORMANT <i>Ms. Gordon Shuler, Elliotts</i>	Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Pancreas</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>157X</i>		(b) DUE TO <i></i>	(c) <i></i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) <i></i>	(County)	(State)
21. I certify that I attended the deceased from <i>10/5/1957</i> to <i>10/16/1957</i> , that I last saw the deceased alive on <i>10/16/1957</i> , and that death occurred at <i>M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i></i>						
ACTUAL SIGNATURE <i>J. H. Deakins</i>	DATE SIGNED <i>10/19/57</i>					
PHYSICIAN'S NAME (Type) <i></i>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial 10/19/57</i>	22b. DATE THEREOF <i>10/19/57</i>	22c. NAME OF CEMETERY OR CREA TORY <i>Elliotts</i>	22d. LOCATION (City, town, or county) <i>Elliotts</i>	(State) <i>Tid</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Father J. J. Kelly</i>	ADDRESS <i>8 N. Market</i>	24a. REC'D BY REGISTRAR DATE <i>10/21/57</i>	24b. REGISTRAR'S SIGNATURE <i>John Maier</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF GRAH

BUREAU V. S.

OCT 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10592

10594

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the record prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Dorchester Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge Md.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 410 Race St. Cambridge Md.		e. STREET ADDRESS 410 Race St.		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Preston	Middle W.	Last Harding	4. DATE OF DEATH Oct. 31, 1957	Month Oct.	Day 31	Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 8/20/1876	9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months 81	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Grocery Business		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Collison W. Harding				14. MOTHER'S MAIDEN NAME Virginia Harding			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Preston W. Harding		Address 410 Race St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerotic C. V. disease. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Cambridge	(County) Maryland	(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Nutrol causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>John Mace Jr.</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						DATE SIGNED 11/1/57
EXAMINER'S NAME (Type) Dr. John Mace Jr.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/2/57	22c. NAME OF CEMETERY OR CREMATORIUM Greenlawn Cemetery		22d. LOCATION (City, town, or county) Cambridge		(State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service Cambridge, Md.				24a. REC'D BY REGISTRAR 11/1/57		24b. REGISTRAR'S SIGNATURE John Mace Jr.	

RECEIVED

NOV 4 1957

BUREAU V. S

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

16

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10607

CERTIFICATE OF DEATH

10595

116

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Wicomico		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 18yr. 5mo. 13da.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tyaskin		d. STREET ADDRESS 22 x 2. 2		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital				d. STREET ADDRESS -		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Florence		First	Middle	Last	4. DATE OF DEATH Horner	Month Oct.	Day 30	Year 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-22-79	9. AGE (In years lost birthday) 78 yrs.	IF UNDER 1 YEAR 5 Months	IF UNDER 24 HRS. 5 Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME James L. Bedsford		14. MOTHER'S MAIDEN NAME Elizabeth Lloyd						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. —		17. INFORMANT RECORDS - E.S.S. Hospital, Cambridge, Maryland		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Anemia DUE TO (c) Cachexia								
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Dementia Praecox, Paranoid Type								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 11-11- 1956 , to 10-30, 1957 , that I last saw the deceased alive on 10-30, 1957 , and that death occurred at 2:50 AM , from the causes and on the date stated above.								
ACTUAL SIGNATURE Edwin J. Ward		ADDRESS (Street, city or town, state) M.D. E.S.S. H., Cambridge, Maryland						DATE SIGNED 10/30/57
PHYSICIAN'S NAME (Type) Edwin J. Ward, M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/3/57		22c. NAME OF CEMETERY OR CREMATORIAL Tyaskin Cemetery		22d. LOCATION (City, town, or county) (State) Tyaskin Md.		
23. FUNERAL DIRECTOR'S SIGNATURE C. D. Measick, Bischoff, 2nd		ADDRESS —		24a. REC'D BY REGISTRAR NOV 5 1957		24b. REGISTRAR'S SIGNATURE John Macpherson		

CERTIFICATE OF DEATH

BUREAU V. S

NOV 5 1957

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10596

Reg. Dist. No.

10608

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Oxonholme</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>Oxonholme</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>East New Market</i>		c. LENGTH OF STAY IN 1b <i>4 weeks</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>East New Market, Md.</i>		d. STREET ADDRESS <i>1</i>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <i>Charles Newbold Jones</i>		First	Middle	Last	4. DATE OF DEATH <i>Oct 22 1957</i>	Month	Doy	Year		
5. SEX <i>F</i>		6. COLOR OR RACE <i>Black</i>	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH <i>Sept 14, 1857</i>	8. AGE (In years last birthday) <i>40 yrs.</i>	9. IF UNDER 1 YEAR Months	10. IF UNDER 24 HRS. Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>				
13. FATHER'S NAME <i>Frederick Jones</i>		14. MOTHER'S MAIDEN NAME <i>Inez Jones</i>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Inez Jones E.N. Market, Md.</i>		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>772.0</i>		DUE TO <i>Malnutrition</i>				INTERVAL BETWEEN ONSET AND DEATH <i>—</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. <i>(b)</i>		DUE TO <i>(c)</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>		20f. (City or town) <i>—</i>		(County) <i>—</i>	(State) <i>—</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <i>John Mace Jr.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							DATE SIGNED <i>10/24/57</i>	
EXAMINER'S NAME (Type) <i>John Mace Jr.</i>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10/24/57</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Salem Md.</i>		22d. LOCATION (City, town, or county) <i>—</i>		(State) <i>—</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles Campbell</i>		ADDRESS <i>East New Market, Md.</i>		24a. REC'D BY REGISTRAR <i>John Mace Jr.</i>		24b. REGISTRAR'S SIGNATURE <i>John Mace Jr.</i>				
VS. A15ME 5M 2/57				DATE <i>10/22/57</i>						
4000247XV6										

BUREAU V. S.

OCT 23 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10597

10593

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Dorchester</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cambridge</i>		c. LENGTH OF STAY IN 1b <i>3 weeks</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Cambridge Md.</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Frank Leo Koski</i>		4. DATE OF DEATH <i>10/19/1957</i>	Month Day Year
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/11/1894</i>
9. AGE (In years last birthday) <i>63 yrs.</i>	10. IF UNDER 1 YEAR Months Days Hours Min. <i>0 0 0 0</i>	11. IF UNDER 24 HRS. <i>0 0 0 0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farming</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own farm</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>Poland</i>	
13. FATHER'S NAME <i>Joseph Koski</i>		14. MOTHER'S MAIDEN NAME <i>Louisa Mickelska</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>47-1111111</i>	
17. INFORMANT <i>Mr Frank Koski, Secretary</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic nephritis</i>		<i>6 mos</i>	
DUE TO <i>260x</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hangnail of left foot</i>		<i>6 mos</i>	
DUE TO <i>Diabetes mellitus</i>		<i>13 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Arteriosclerotic Ht. Disease</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>136 Race St</i>		20f. (City or town) (County) (State) <i>Cambridge Dorchester Del</i>	
21. I certify that I attended the deceased from <i>May 4</i> , 1957, to <i>Oct 19</i> , 1957, that I last saw the deceased alive on <i>Oct 18</i> , 1957, and that death occurred at <i>2:30 AM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>136 Race St Cambridge, Md</i>			
ACTUAL SIGNATURE <i>Alfred R. Maryanov</i>		DATE SIGNED <i>10/22/57</i>	
PHYSICIAN'S NAME (Type) <i>ALFRED R. MARYANOV</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial 10/22/57</i>		22b. DATE THEREOF <i>10/22/57</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Cambridge Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Cambridge Dorchester Del</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ruth Bellamy E. N. Relet Jr.</i>		24a. REC'D BY REGISTRAR DATE 10/23/57	
		24b. REGISTRAR'S SIGNATURE <i>John Macias</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WILLIAM D. GARNER—DEPARTMENT OF HEALTH—BALTIMORE 18

CERTIFICATE OF DEATH

BUREAU V. S.
RECEIVED
OCT 30 1957

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										10598	
CERTIFICATE OF DEATH										Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Madison		c. LENGTH OF STAY IN 1b 			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO Rural-Madison						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 					d. STREET ADDRESS /			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) John Francis Marine		First	Middle	Last	4. DATE OF DEATH Oct 26, 1957		Month	Day	Year		
S. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 20, 1882		9. AGE (In years last birthday) 74 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmhand			10b. KIND OF BUSINESS OR INDUSTRY Farming			11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME David R. Marine					14. MOTHER'S MAIDEN NAME Sarah Jane Keene						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-14-8523		17. INFORMANT John W. Marine, Church Creek, Md.		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Atherosclerosis CV Disease</i> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <i>Arterio - sclerotic gen secur</i>										INTERVAL BETWEEN ONSET AND DEATH ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Emaciation</i>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 									
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Cambridge		(County) Md.	(State) MD		
21. I certify that I attended the deceased from Oct 1 , 19 57 , to Oct 26 , 19 57 , that I last saw the deceased alive on Oct 24 , 19 57 , and that death occurred at M. from the causes and on the date stated above.										ADDRESS (Street, city or town, state) Cambridge, Md.	DATE SIGNED Oct 28/57
ACTUAL SIGNATURE <i>Sarah Jane Keene</i>										PHYSICIAN'S NAME (Type) <i>Hugh M. Mallon Jr.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/30/1957		22c. NAME OF CEMETERY OR CREMATORIUM Madison Cemetery			22d. LOCATION (City, town, or county) Madison, Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hugh M. Mallon Jr.</i>		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR John Mae Jr.		24b. REGISTRAR'S SIGNATURE John Mae Jr.					

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10594

CERTIFICATE OF DEATH

10599

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL, and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Cambridge			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital		d. STREET ADDRESS RFD #3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Leroy	Middle Matthews	Last Matthews	4. DATE OF DEATH Oct.	Month 3,	Day 1957	Year
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 22, 1897	9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmhand		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Dorchester Co., Md,		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John W. Matthews			14. MOTHER'S MAIDEN NAME Hager Matthews			Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Jefferson Matthews, Cambridge, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 177X Coramomitisis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Adenocarcinoma Prostate DUE TO (c)	
INTERVAL BETWEEN ONSET AND DEATH 2 yrs							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from June 4, 1957, to Oct. 13, 1957, that I last saw the deceased alive on Oct. 13, 1957, and that death occurred at 5 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE W. H. Hanks W. H. Hanks PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/7/1957		22c. NAME OF CEMETERY OR CREMATORIUM Waugh Cemetery		22d. LOCATION (City, town, or county) Cambridge, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Herbert McPherson		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR DATE 10/14/57		24b. REGISTRAR'S SIGNATURE John Mae Jr.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician and completely filled in by the funeral director.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CALIFORNIA STATE GOVERNMENT OF HEALTH-BALTIMORE FA

CERTIFICATE OF DEATH

DEATH CERTIFICATE

NAME

ADDRESS

CITY

STATE

ZIP

PHONE

AGE

SEX

RACE

MATERIAL

TESTS

EXAMINER

LABORATORY

BUREAU Y. S

OCT 17 1957

RECEIVED

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10595 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending", in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the remains prior to burial, cremation, or removal.

10600

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b All life		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Maryland Hospital				d. STREET ADDRESS 11 Phillips St.						
3. NAME OF -DECEASED (Type or print)		First Linda	Middle Laverne	Last Meekins	4. DATE OF DEATH	Month October	Day 28	Year 1957		
5. SEX Female		6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 3/9/52	9. AGE (In years last birthday) 5 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY None			11. BIRTHPLACE (State or foreign country) Maryland				
12. CITIZEN OF WHAT COUNTRY? USA.										
13. FATHER'S NAME Clarence Elmer Meekins				14. MOTHER'S MAIDEN NAME Allien Curtis						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. None			17. INFORMANT Address Hospital Records Cambridge, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia due to acute gastroenteritis. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c)										
INTERVAL BETWEEN ONSET AND DEATH 1 Day										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No injury							
20c. TIME OF INJURY Hour o. m. p. m.			Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Cambridge	(County) 0	(State) MD
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <i>John Mace Jr.</i>		DATE SIGNED 10/31/57								
EXAMINER'S NAME (Type) Dr. John Mace Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 10/31/57		22c. NAME OF CEMETERY OR CREMATORIUM Bethel Cemetery		22d. LOCATION (City, town, or county) Cambridge, Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE Herbert St. Clair				ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR 10/31/57		24b. REGISTRAR'S SIGNATURE John Mace Jr.		
VS. A15ME(5) 5M 9/55		<i>ASST</i>								

RECEIVED		NOV 4 1957	
BUREAU V. S.			
FEDERAL BUREAU OF INVESTIGATION U. S. DEPARTMENT OF JUSTICE WICHITA FIELD OFFICE WICHITA, KANSAS			
EXAMINER'S CERTIFICATE OF DATE			
1957			
SEARCHED INDEXED SERIALIZED FILED			
FBI - WICHITA			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10610 CERTIFICATE OF DEATH

10601

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY		Eastern Shore State Hosp. Dorchester Co., Maryland		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN b RURAL and give nearest town Cambridge		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Eastern Shore State Hosp.		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
Male	White		MELVIN	October	5	19	57
6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?				

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Melvin	Esther Draper

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
Unknown		Medical Record	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Embolus		
422.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		
DUE TO (b) Amputation of left leg (Mid-thigh)		
DUE TO (c) Chronic Cardiovascular Disease		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
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21. I certify that I attended the deceased from Oct. 5, 1957, to Oct. 5, 1957, that I last saw the deceased alive on Oct. 5, 1957, and that death occurred at 5:50 P.M., from the causes and on the date stated above.	ADDRESS (Street, city, town, state)	DATE SIGNED
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ACTUAL SIGNATURE ETTORE DE FILIPPI	M.D. Eastern Shore State Hosp. Oct. 5/1957	
PHYSICIAN'S NAME (Type)	ETTORE DE FILIPPI	

22a. FUNERAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIAL	22d. LOCATION (City, town, or county) (State)
Burial Oct. 10, 1957	11/1/57	Mt. Olive	Sandtown, Del.

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE 10/9/57	24b. REGISTRAR'S SIGNATURE
George W. Morrison	(Denton)		John MacLean Jr.

DEPARTMENT OF HEALTH - CALIFORNIA

CERTIFICATE OF DEATH

RECEIVED

BUREAU V. A.

OCT 14 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10596

CERTIFICATE OF DEATH

10602

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Dorchester Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Dorchester Co.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.	c. LENGTH OF STAY IN 1b In Ambulance	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Toddvile Md. x2				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION In Ambulance	e. STREET ADDRESS Toddvile Md.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Rosie	First Todd	Middle Meredith	4. DATE OF DEATH Oct. 19, 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 3/12/1882	9. AGE (in years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Crocheron Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William Todd		14. MOTHER'S MAIDEN NAME Malvinia Bramble				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs. Doris James	Address 12 Washington St., Cambridge Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arteriosclerotic Heart Disease (c) Hypertension		Cardiac decompensation		INTERVAL BETWEEN ONSET AND DEATH 2 days		
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				4 yrs		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 136 Race St	(County)	(State)
21. I certify that I attended the deceased from <u>Assy 6</u> , 1957, to <u>Oct 19</u> , 1957, that I last saw the deceased alive on <u>Oct 19</u> , 1957, and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <u>Alfred R. Maryanov</u> M.D. DATE SIGNED <u>10/14/57</u> PHYSICIAN'S NAME (Type) <u>ALFRED R. MARYANOV</u> Cambridge, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/22/1957	22c. NAME OF CEMETERY OR CREMATORIUM Dorchester Mem Park	22d. LOCATION (City, town, or county) Cambridge Md.	(State)		
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service	ADDRESS Cambridge Md.	24a. REC'D BY REGISTRAR John Meed Jr.	24b. REGISTRAR'S SIGNATURE			
VS A15 (4) 15M 9/55		DATE 10/22/57				

BUREAU V. S.

1957 Oct 100

REGELIVEL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10597

CERTIFICATE OF DEATH

10603

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 25 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge		b. COUNTY Dorchester		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Race Street ext.				d. STREET ADDRESS Race Street ext.				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)	First Mayme	Middle Parker	Last Mills	4. DATE OF DEATH	Month Oct. 1, 1957	Day 19	Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 22, 1892	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Woolford, Md.		
12. CITIZEN OF WHAT COUNTRY? U.S.								
13. FATHER'S NAME Clifton J. Parker				14. MOTHER'S MAIDEN NAME Daura Stewart				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Stewart O. Parker, Cambridge, Md. R.F.D. 3		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X DUE TO Alveolar cell carcinoma right lung with metastases INTERVAL BETWEEN ONSET AND DEATH 3 years								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Aug 9 , 1957, to Oct 1 , 1957, that I last saw the deceased alive on Sept. 30 , 1957, and that death occurred at 7.10 A.M. from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) City Office Bldg. DATE SIGNED 10/5/57								
ACTUAL SIGNATURE Lewis M. Burdette M.D.								
PHYSICIAN'S NAME (Type) Lewis M. Burdette Cambridge, Md.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 3, 1957		22c. NAME OF CEMETERY OR CREMATORIAL Dorchester Memorial Park		22d. LOCATION (City, town, or county) (State) Cambridge, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth R. Shonan				ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR John Grace Jr.		
						24b. REGISTRAR'S SIGNATURE		
						DATE 10/5/57		

CERTIFICATE OF DEATH

WISCONSIN STATE DOCUMENT OF DEATH-BALLINGER

BUREAU V.
RECEIVED
OCT 7 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10598

10604

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the remains prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Dorchester				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		d. STREET ADDRESS 213 Pine Street		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 140 Pine Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Elwood		First	Middle	Last	4. DATE OF DEATH Month	Day	Year	
5. SEX Male		6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 22, 1909				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restaurant		10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) Worcester Co., Md.		9. AGE (In years last birthday) 47 yrs.		
13. FATHER'S NAME James Mitchell				14. MOTHER'S MAIDEN NAME Viola Jones				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 213-22-7006		17. INFORMANT Beatrice Mitchell, Cambridge, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DUE TO (c)								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH -----		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----						
20c. TIME OF INJURY Month, Day, Year Hour o. m. -- p. m. -- 19		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) -----	(County) -----	(State) -----
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>Eldridge H. Wolff</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
EXAMINER'S NAME (Type) Eldridge H. Wolff, M.D.				DATE SIGNED 10-2-57				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/5/1957		22c. NAME OF CEMETERY OR CREMATORIAL Family Burial Ground		22d. LOCATION (City, town, or county) (State) East New Market, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Herbert W. Wolff Jr.</i>				ADDRESS Cambridge, Md.				
VS. A15ME(5) 5M 9/55				24a. REC'D BY REGISTRAR DATE 10/10/57				
24b. REGISTRAR'S SIGNATURE <i>John MacIn</i>								

THE EXAMINER'S CERTIFICATE OF DEATH

BUREAU V.

OCT 14 1957

REGELIV ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10695

Reg. Dist. No.

10599

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the records prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

1. PLACE OF DEATH o. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Dorchester Co.				o. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		b. COUNTY Dorchester Co.	
Cambridge Md.		3 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Cambridge Md. Hospital		Honga, Md.			
3. NAME OF DECEASED (Type or print)		First Clarence	Middle B.	Last Parker	4. DATE OF DEATH Oct. 29, 1957
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 18, 1888	9. AGE (in years last birthday) 69 yrs.
					IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Waterman		Fishing		Honga, Md.	
13. FATHER'S NAME Charles M. Parker		14. MOTHER'S MAIDEN NAME Dora Creighton		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT George W. Parker 2925 Sisson St. Baltimore, Md.	
				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH 2 days			
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)		Petechial hemorrhages brain.			
812X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO (b)			
		DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was struck by car while walking on Rt. 335.			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 5:30 10/27 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt. 335 20f. (City or town) (County) (State) Fishing Creek, Dor. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>John Mace Jr.</i>		DATE SIGNED 10/31/57			
EXAMINER'S NAME (Type) Dr. John Mace Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/1/57		22c. NAME OF CEMETERY OR CREMATORIUM Hoosier Church	
22d. LOCATION (City, town, or county) Fishing Creek Md.					
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service Cambridge Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE 10/31/57	
				24b. REGISTRAR'S SIGNATURE <i>John Mace Jr.</i>	

WEDNESDAY EVENING DECEMBER 18
NEW YORK STATE CAPITAL, ALBANY

BUREAU V.

NOV 4 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10606
116

10611

CERTIFICATE OF DEATH

Reg. Dist. No. 64

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 27 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg		05x22			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital				d. STREET ADDRESS — Morris Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Minnie	Middle 	Last Parrott	4. DATE OF DEATH Oct. 29 1957	Month Oct.	Day 29	Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-25-81	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months 	IF UNDER 24 HRS. Days 	Hours 	Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Wesley Downes		14. MOTHER'S MAIDEN NAME Sallie E. Downes (maiden name: Willey)							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT RECORDS - Eastern Shore State Hosp., Cambridge, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary thrombosis		INTERVAL BETWEEN ONSET AND DEATH							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Pyelitis									
(c) DUE TO Myocarditis, chronic									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebral Arteriosclerosis With Psychosis								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from alive on 10-29 1957 , to 10-29 1957 , and that death occurred at 12:50 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) E.S.S.Hospital, Cambridge, Md.							
ACTUAL SIGNATURE <i>Edwin J. Ward</i>		DATE SIGNED 10/29/57							
PHYSICIAN'S NAME (Type) Edwin J. Ward, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 1, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Hill Crest Cemetery		22d. LOCATION (City, town, or county) Federalsburg, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Hampton Jr.</i>		ADDRESS Federalsburg, Maryland		24a. REC'D BY REGISTRAR DATE 11-1-57		24b. REGISTRAR'S SIGNATURE <i>Angela H. Hampton John Grace, Jr.</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU U. S.

NOV 7 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10607

10600

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b Few days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Vienna			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 1			
3. NAME OF DECEASED (Type or print)	First Frances	Middle Alverta	Last Payton	4. DATE OF DEATH Oct. 22 1957	Month Oct.	Day 22	Year 1957
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 30, 1903	9. AGE (In years less birthday) 54 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Food Packing		11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Henry Stanley		14. MOTHER'S MAIDEN NAME Christina Pinder		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Walter Stanley, Cambridge, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Measles DUE TO 592x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chv. Nephritis DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH 8 days. ?							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/21/57 to 10/27/57 , that I last saw the deceased alive on 10/22/57 , and that death occurred at 8:00 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE H. H. Blanks		ADDRESS (Street, city or town, state) 104 Locust St. Cambridge, Md.					
PHYSICIAN'S NAME (Type) W. H. Blanks		DATE SIGNED 10/25/57					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/27/1957		22c. NAME OF CEMETERY OR CREMATORIUM Crossroads		22d. LOCATION (City, town, or county) (State) Dorchester Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Herbert M. Sullivan Jr.		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR DATE 10/30/57		24b. REGISTRAR'S SIGNATURE John Mae Jr.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-SANITATION

CERTIFICATE OF DEATH

NOV 4 1957

NAME

ADDRESS

CITY

STATE

ZIP

BUREAU V.

NOV 4 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10612

CERTIFICATE OF DEATH

10608

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b one day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Hurlock				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Elisha	Middle -	Last Phillips	4. DATE OF DEATH October 22 1957	Month October	Day 22	Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 24, 1893	9. AGE (In years lost birthday) 64 yrs.	IF UNDER 1 YEAR Months -	IF UNDER 24 HRS. Days -	Hours -	Min. -
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Night watchman		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Rink Phillips			14. MOTHER'S MAIDEN NAME Sally Turner					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. -		17. INFORMANT RECORDS: Eastern Shore State Hospital		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Cardio-vascular disease DUE TO (c) General Arteriosclerosis								
INTERVAL BETWEEN ONSET AND DEATH								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 10-21 1957 to 10-22-57 19 , that I last saw the deceased alive on 10-22 1957 , and that death occurred at 11:55 p.m. from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) ADDRESS DATE SIGNED								
ACTUAL SIGNATURE Ettore DeFilippis M.D.								
PHYSICIAN'S NAME (Type) Ettore DeFilippis Eastern Shore State Hospital, Cambridge, Md.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 10/25/57		22b. DATE THEREOF 10/25/57		22c. NAME OF CEMETERY OR CREMATORIUM Washington		22d. LOCATION (City, town, or county) Hurlock, Md.		
(State)								
23. FUNERAL DIRECTOR'S SIGNATURE John J. Doherty		ADDRESS 101 S. Calvert St. Baltimore, Md.		24e. REC'D BY REGISTRAR John J. Doherty		24b. REGISTRAR'S SIGNATURE John J. Doherty		
DATE 10/24/57								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DRAFT COPY

NAME:

DECEASED:

DECEASED:

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DECEIVED
BUREAU V. S.

OCT 30 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10609

10613

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH o. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 11yr. 3mo. 11das.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill		d. STREET ADDRESS 23x0-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital				d. STREET ADDRESS -		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Walter		First	Middle q.	Last Porter	4. DATE OF DEATH October 20 1957	Month	Day	Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-23-76	9. AGE (In years lost birthday) 80 yrs.	IF UNDER 1 YEAR Months 80	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George W. Porter			14. MOTHER'S MAIDEN NAME Tobitha Anne Blades						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unkn.		16. SOCIAL SECURITY NO. None		17. INFORMANT RECORDS - Eastern Shore State Hospital		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of liver with metastasis to stomach and mesenteric glands DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic myocarditis DUE TO (c) Ascites - Incontinence of intestine									
INTERVAL BETWEEN ONSET AND DEATH									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) ADDRESS (Street, city or town, state)							
20c. TIME OF INJURY Month, Day, Year Hour o. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Snow Hill		(County) Worcester	(State) Md.
21. I certify that I attended the deceased from 11-11 1956 to 10-20 1957 , that I last saw the deceased alive on 10-20 1957 , and that death occurred at 4:45 P.M. from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) M.D. Eastern Shore St. Hospital, Cambridge, Md.									DATE SIGNED 10-21-57
ACTUAL SIGNATURE <i>Edwin J. Ward</i>		PHYSICIAN'S NAME (Type) Dr. Edwin J. Ward							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct 23 1957		22c. NAME OF CEMETERY OR CREMATORIAL Eastern Methodist		22d. LOCATION (City, town, or county) Snow Hill			
23. FUNERAL DIRECTOR'S SIGNATURE <i>James J. Macer Jr.</i>		ADDRESS 10613 Snow Hill Md.							
		24a. REC'D BY REGISTRAR Oct 24 1957							
		24b. REGISTRAR'S SIGNATURE Dr. J. Macer Jr.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Part may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF HEALTH - BALTIMORE CITY
CERTIFICATE OF DEATH

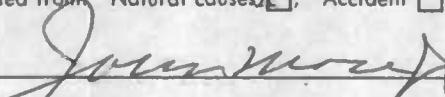
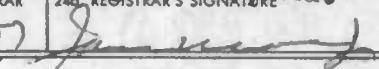
BUREAU V. S.

OCT 24 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the remains prior to burial or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										10610
										Reg. Dist. No.
1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Dorchester					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge			c. LENGTH OF STAY IN 1b 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Fishing Creek					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Maryland Hospital					d. STREET ADDRESS /					
3. NAME OF DECEASED (Type or print) First Alma Middle Phillips Last Rhea					4. DATE OF DEATH Oct. 1 1957					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/22/02		9. AGE (In years last birthday) 55 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME William Phillips					14. MOTHER'S MAIDEN NAME Mobalia Parker					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. No 212 12 3909			17. INFORMANT William Ivy Rhea		Address Fishing Creek, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus										5 Min.
465X DUE TO Condition, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Phlebothrombosis right femoral vein.										?
DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.										
ACTUAL SIGNATURE 		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>								
										DATE SIGNED 10/2/57
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/2/57		22c. NAME OF CEMETERY OR CREMATORIUM Hoosier Cemetery			22d. LOCATION (City, town, or county) Fishing Creek Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service Cambridge, Md.										
ADDRESS Le Compte Funeral Service Cambridge, Md.					24a. REC'D BY REGISTRAR DATE 10/2/57					
					24b. REGISTRAR'S SIGNATURE 					

EDUCATIONAL EXAMINATIONS CERTIFICATE OF LEARNER

BUREAU Y.

OCT 7 1957

REGELIVEL

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10611

Reg. Dist. No.

10602

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the records prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge.		c. LENGTH OF STAY IN 1b 4 months.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton, Maryland.		d. STREET ADDRESS 7 Brookletts Avenue.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Emory	Middle A.	Last Ross.	4. DATE OF DEATH Oct. 25, 1957.	Month Day Year	19
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 1/6/1883	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor		10b. KIND OF BUSINESS OR INDUSTRY Retired.		11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Bernard W. Ross		14. MOTHER'S MAIDEN NAME Willie Jones.					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Alice Leonard/		Address Easton, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion						Instant	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1							
{ (b)							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>John Mace Jr.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 10/28/57	
EXAMINER'S NAME (Type) Dr. John Mace Jr.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 28, 57		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Spring Hill		22d. LOCATION (City, town, or county) Easton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE R. Ellis Clark				24a. REC'D BY REGISTRAR John Mace Jr.		24b. REGISTRAR'S SIGNATURE	
				DATE 10/28/57			

MANITOBA STATE POLICE - BUREAU OF MEDICAL EXAMINERS - DEPARTMENT OF

BUREAU V.

OCT 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10612

10614

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taylor's Island, Rural		c. LENGTH OF STAY IN 1b entire life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taylor's Island, Rural			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural		d. STREET ADDRESS Rural		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Edward	Middle R.	Last Ruark	4. DATE OF DEATH Oct. 19, 1957	Month Oct.	Day 19	Year 19
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 3, 1874	9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer self-employed		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Taylor's Island		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George W. Ruark		14. MOTHER'S MAIDEN NAME Nancy Moore					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] No		16. SOCIAL SECURITY NO. No		17. INFORMANT Albanus Ruark, Cambridge, Md. R.F.D. 3		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		Myocardial Failure		INTERVAL BETWEEN ONSET AND DEATH 2wks		?	
Carteriosclerosis		Arteriosclerosis					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Carcinoma penis with metastasis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-10 1956, to 10/19 1957, that I last saw the deceased alive on 10/19 1957, and that death occurred at 5:45 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE W. H. Hanks						ADDRESS (Street, city or town, state) 104 Locust St Cambridge Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 21, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Bethlehem Churchyard		22d. LOCATION (City, town, or county) Taylor's Island, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Katherine R. Thomas		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR DATE 10/22/57		24b. REGISTRAR'S SIGNATURE John MacLean Jr.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10613

Reg. Dist. No.

10603

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 30 years		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 38 Glasgow Street		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge		
d. STREET ADDRESS 38 Glasgow Street.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First John	Middle Summerfield	Last Skinner	
4. DATE OF DEATH	Month October	Day 28, 1957	Year 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 19, 1972	
9. AGE (In years last birthday) 84	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	
13. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired County Treasurer	10b. KIND OF BUSINESS OR INDUSTRY Cambridge R.F.D.	11. BIRTHPLACE (State or foreign country) Cambridge R.F.D.	12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Alexander Skinner	14. MOTHER'S MAIDEN NAME Sallie Lurty	Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. No	17. INFORMANT Nellie P. Skinner, 38 Glasgow St., Cambridge, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia			INTERVAL BETWEEN ONSET AND DEATH 2 days	
442X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. } (b) Arteriosclerotic Hypertensive cardio vascular			renal disease 10 years	
DUE TO (c) Arteriosclerosis, generalized and cerebral			10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 260X Diabetes mellitus			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. m. p. m.	Month --- 19	20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at Work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---	20f. (City or town) --- (County) --- (State) ---
21. I certify that I attended the deceased from 3-5-46 , 19 to 10-28-57 , 19, that I last saw the deceased alive on 10-27-57 , 19, and that death occurred at 12:00 Noon , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Eldridge H. Wolff, M.D. 15 Locust Street, Cambridge, Md. DATE SIGNED 10-29-57				
ACTUAL SIGNATURE <i>Eldridge H. Wolff</i>	PHYSICIAN'S NAME (Type) Eldridge H. Wolff, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 30, 1957	22c. NAME OF CEMETERY OR CREMATORIUM Old Trinity Churchyard	22d. LOCATION (City, town, or county) Church Creek, Md.	(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Kenneth R. Shoules</i>	ADDRESS Cambridge, Md.	24a. REC'D BY REGISTRAR 11/1/57	24b. REGISTRAR'S SIGNATURE <i>John Nease Jr.</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MANUFACTURED STATE-DEPARTMENT OF HAWAII-AELEIWAHE, 18

CERTIFICATE OF DEATH

BUREAU V. S.

NOV 4 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10614

10615

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Dorchester MARYLAND		o. STATE Md. b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 5 days	
Cambridge		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg 05x23	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hosp.		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
GEORGE		SMITH	JR.
4. DATE OF DEATH		Month Oct.	Day 6
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>
Male White		B. DATE OF BIRTH Mar. 7 1883	
9. AGE (In years lost birthday) 74 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired.) Block factory some		10b. KIND OF BUSINESS OR INDUSTRY	
10c. BIRTHPLACE (State or foreign country) Maryland		11. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Smith		14. MOTHER'S MAIDEN NAME Mukowne	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. 22-1-10-5028	
17. INFORMANT Harvey Willin		Address Federalsburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1		Cardiac Failure	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		Chronic Cardio-vascular disease	
DUE TO (b)		Generalized Arteriosclerosis	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 5, 1957 to Oct. 6, 1957, that I last saw the deceased alive on Oct. 6, 1957, and that death occurred at 7:45 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE ETTORE DEFILIPPIS M.D. Eastern Shore State Hosp.			
PHYSICIAN'S NAME (Type) ETTORE DEFILIPPIS		Cambridge, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/18/1957	
22c. NAME OF CEMETERY OR CREMATORIAL Cathaway Cemetery		22d. LOCATION (City, town, or county) Federalsburg - rural	
23. FUNERAL DIRECTOR'S SIGNATURE Harvey Willin - Federalsburg, Md.		24a. REC'D BY REGISTRAR DATE 10/15/57	
		24b. REGISTRAR'S SIGNATURE John Macgr.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WISCONSIN STATE DEPARTMENT OF HEALTH - SALINOMEX 18

CERTIFICATE OF DEATH

DECEASED

BUREAU V.

OCT 17 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10615

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE MARYLAND															
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Cambridge		c. LENGTH OF STAY IN lb 8 Years		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Rural Cambridge, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge, Md. RFD# 3		d. STREET ADDRESS Cambridge, Md. RFD # 3		4. DATE OF DEATH Month Day Year Oct. 24 1957															
3. NAME OF DECEASED (Type or print) Sadie		First Sadie Middle Amelis Last Stewart		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/31/1900		9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months 57 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Edward O. Seward				14. MOTHER'S MAIDEN NAME Olive Davis				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None				17. INFORMANT Mr. J. Alfred Stewart Cambridge Rt. 3			
Address																			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]																			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion INTERVAL BETWEEN ONSET AND DEATH Instant																			
420.1 DUE TO																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)																			
DUE TO (c)																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)																			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																			
ACTUAL SIGNATURE <i>John Mace Jr.</i> DATE SIGNED 10/25/57																			
EXAMINER'S NAME (Type) Dr. John Mace Jr. M.D. CHIEF MEDICAL EXAMINE <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>																			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 26/57		22c. NAME OF CEMETERY OR CREMATORIUM Dorchester Mem. Park		22d. LOCATION (City, town, or county) Cambridge, Md.		(State)											
23. FUNERAL DIRECTOR'S SIGNATURE LeCompt Funeral Service Cambridge, Md.				ADDRESS		24a. REC'D BY REGISTRAR 10/25/57		24b. REGISTRAR'S SIGNATURE John Mace Jr.											

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the remains or prior to burial, or removal.

BUREAU V. S.

OCT 30 1957

REGEV E

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10616

10617

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge		c. LENGTH OF STAY IN 1b 3 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		d. STREET ADDRESS 205 E. Isabella St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First MARY	Middle COLLINS	Last TILGHMAN	4. DATE OF DEATH Oct. 21	Month 1957	Day	Year
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/20/63	9. AGE (In years lost birthday) 9 1/2 yrs.	IF UNDER 1 YEAR Months 9	IF UNDER 24 HRS. Days 1	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Ed J. Collins				14. MOTHER'S MAIDEN NAME Mary E. Lockwood			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. no		17. INFORMANT Eastern Shore State Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) General arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Senile Psychosis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ADDRESS (Street, city or town, state)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 27, 1954 , to Oct. 21, 1957 , that I last saw the deceased alive on Oct. 21, 1957 , and that death occurred at 10:15a M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Thomas J. Dredge M.D. E.S.S. Hospital, Cambridge, Md. 10/21/57							
PHYSICIAN'S NAME (Type) Thomas J. Dredge		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/23/1957		22c. NAME OF CEMETERY OR CREMATORIUM Parsons Cemetery		22d. REG'D BY REGISTRAR DATE Oct 24 1957	
23. FUNERAL DIRECTOR'S SIGNATURE The Hill & Johnson Co. Salisbury, Md. Dr. J. Mace Jr.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 24 1957

REGELY ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10618

-10604

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Md.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY			
Cambridge		2 wks		Secretary		Dor.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Cambridge Maryland									
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4. DATE OF DEATH	Month	Day	Year	
Male		Daniel	Martina	Webster	12/1/1874	8x	10	8	1957
6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years at birthday) yrs.	10. IF UNDER 1 YEAR Months		11. IF UNDER 24 HRS. Days Hours Min.	
white			12/1/1874		8x				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Merchant		Own Store		Maryland		Md. A			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
Harrison Webster		Martha Lankford							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
(No)				Reymond C. Webster - Secretary Mkt.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		MYOCARDIAL INFARCTION				INTERVAL BETWEEN ONSET AND DEATH INSTANT			
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } (b) } DUE TO } (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o.m. p.m.		Month 19	Day	Year 1957	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 105 CHURCH ST	(County) 105 CHURCH ST	(State) MD
21. I certify that I attended the deceased from alive on		9/29/59		1959 to 10/18/57		1957 that I last saw the deceased and that death occurred at 12:10 M.			
						from the causes and on the date stated above. ADDRESS (Street, city or town, state) WALTER E. GUNBY, JR. 105 CHURCH ST			
ACTUAL SIGNATURE						DATE SIGNED 10/19/57			
PHYSICIAN'S NAME (Type)		WALTER E. GUNBY, JR.		CAMBRIDGE MD					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)		(State)	
Burial 10/10/57		East New Market		East New Market		East New Market, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
Walter E. Gunby, Jr., East New Market, Md.				John Mace Jr.					
DATE 10/9/57									

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

1957

RECEIVED
BUREAU V. S.

OCT 14 1957